DOCUMENT RESUME

ED 251 782 CG 017 911

AUTHOR Kahana, Eva; And Others
TITLE Social Factors in Institutional Living.
PUB DATE Aug 84
NOTE 40p.; Paper presented at the Annual Convention of the American Psychological Association (92nd, Toronto, Ontario, Canada, August 24-28, 1984).
PUB TYPE Information Analyses (070) -- Reports - Research/Technical (143) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS *Institutional Environment; *Institutionalized Persons; Literature Reviews; Longitudinal Studies; Nursing Homes; *Older Adults; Psychological Patterns; Social Adjustment; *Social Environment
IDENTIFIERS Long Term Care Facilities

ABSTRACT

This first section of this paper reviews the literature on the social world of the institutionalized elderly. Social factors contributing to institutionalization are discussed, including the personal and psychological background of residents. Social behavior and the institutional environment are reviewed, focusing on social interactions among residents, between residents and staff, and between residents and non-residents. The role of social factors in institutional outcomes is also discussed, and a model of social factors in institutional life is presented. The second section of the paper presents data from a longitudinal study of the initial year of institutional living of residents (N=253) who were studied from the pre-institutional stage, before entering diverse institutional environments. They were compared with 35 residents entering a senior citizen housing site. Residents' self-reports, and staff and interviewer observations of their interactions indicated that they not only survived the move and early adjustment period, but generally found life in a congregate facility to be no worse than they expected, or in many cases, better than expected. The primary motivating factors for institutional entry frequently were social in nature, and most residents were willing or eager to move and expected their stay to be permanent. Social interactions remained stable. The elderly received frequent visitors, reported generally pleasant interactions with other residents and staff, and participated in activities at the institution, although there was little increase in close and meaningful social ties. (JAC)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED251782

SOCIAL FACTORS IN INSTITUTIONAL LIVING

Eva Kahana, Ph.D.
Case Western Reserve University

Boaz Kahana, Ph.D.
Cleveland State University

Rosalie F. Young, Ph.D.
Wayne State University

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☐ This document has been reproduced as received from the person or organization originating it.

☒ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Eva Kahana

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

CG 017911

Paper presented at the Annual Convention of the American Psychological Association, Toronto, Canada, August 24-28, 1984.

SOCIAL FACTORS IN INSTITUTIONAL LIVING

Eva Kahana, Ph.D.
Case Western Reserve University

Boaz Kahana, Ph.D.
Cleveland State University

Rosalie F. Young, Ph.D.
Wayne State University

Introduction

The social world of institutionalized elderly is typically considered in terms of a circumscribed set of social interactions centered around staff-patient, patient-patient and visitor-patient exchanges. There has been extensive documentation within the gerontological literature of the shrinking social interactions of the institutionalized elderly (Tobin and Lieberman, 1976; Gubrium, 1975). Yet a more thorough consideration of the social world of the institutionalized older person reveals a complex set of social paradoxes, contingencies and influences which touch upon diverse aspects of human interconnectedness.

The potential stress presented by institutional life has been well documented in the gerontological literature. Goffman's (1961) classic work has identified characteristics of total institutions which may result in stripping residents of their previous social and personal identity. Townsend (1962) noted the social paradox of life in institutions where the older resident remains alone amidst crowded conditions of living. Lieberman and Tobin (1983) have documented the sense of separation and rejection experienced by many institutionalized elderly.

Negative psychosocial effects of institutional living have been attributed to diverse influences ranging from relocation stress (Tobin and Lieberman, 1976) to inactivity (Gottesman and Bourstrom, 1974), overmedication (Gresham, 1976), excessive staff turnover (Kiyak and Kahana, 1983) and dehumanizing treatment by staff (Gubrium, 1975; Kahana, 1975). An underlying concern with such a broad spectrum of potentially negative environmental influences is the

Paper presented at A P A meetings, 1984, Toronto

assumption that the more vulnerable the older person, the more severely he/she may be affected by adverse environmental conditions (Lawton, 1980).

It has been generally argued that long term care institutions have a depersonalizing effect upon residents (Coe, 1965; Lieberman, 1969) which diminish patterns of social interaction. Furthermore, when old people enter institutions, the social relationships that previously sustained their social identities in the community become less accessible. Yet, studies of institutionalization have challenged previous assumptions regarding negative effects and decline brought about by institutional placements (Spasoff, Kraus, Beattie, Holden, Lawson, Rodenburg and Woodcock, 1978; Kahana and Kahana, 1984). It is now recognized that specific characteristics of persons entering institutions as well as specific features of the environment must be understood in considering the impact of institutionalization on the elderly. Accordingly, under the right circumstances, institutional life may present some potentials for positive growth experiences while it also clearly requires readaptation and may impose constraints on lifestyles of the elderly (Kahana and Kahana, 1984).

Upon entering an institution, there may be a natural drop in some interactions due to a change in accessibility to old friends and relatives. Yet people who previously were isolated due to limitations of mobility are nearer to others and in a social context where there is a potential for developing new relationships. This was noted by Carp (1968) in a study of older persons relocating into a special housing environment (i.e. an apartment complex). The interpersonal environment of this congregate setting provided opportunities for interaction with others which in turn enhanced the well-being of residents.

Anthropological research in age-homogeneous communities reveals that age may indeed provide a foundation for community (Fry, 1979; Hendel-Sebestyen, 1979), and studies of mobile home parks, highrise public housing and retirement communities (Keith, 1982) suggest that older people in these settings engage in extensive social interactions, feeling part of a collectivity. However, new social opportunities in institutions as well as constraints on social relationships are influenced by the institution's policies and procedures. The impact of these constraints and opportunities may vary based upon characteristics of the resident, the institutional social environment and previous social relationships of the resident.

As these findings suggest, there is a broad spectrum of social concerns which may shape the social world of the institutionalized person and influence institutional outcomes. Diverse pre-institutional and institutional social and personal factors affect both entry decisions and social behavior.

1. First, one must consider social factors as they may contribute to or precipitate institutionalization. Social interactions with family or other significant others or the absence of such interactions may figure prominently in these institutional decisions.

2. The psychological background of the resident including personality disposition of extraversion-introversion, preferences for solitary vs. interpersonal activities, and strategies of coping which involve social behaviors represent the personal orientation upon which the social world of the resident rests.

3. The social milieu of the institution in terms of availability of social contacts, social activities, and behavior setting where social activities take place, comprise the environmental context of the resident's social world. Such group environmental factors (Lawton, 1980) need to be considered in terms

of policies, value orientations and staffing patterns which affect social behavior.

4. Social interactions within the institution comprise a fourth area of concern representing the interactive dimension between personal orientation of residents and the social climate of the institution. Relationships with staff, other residents and continuing interactions with family and community representatives must be considered here.

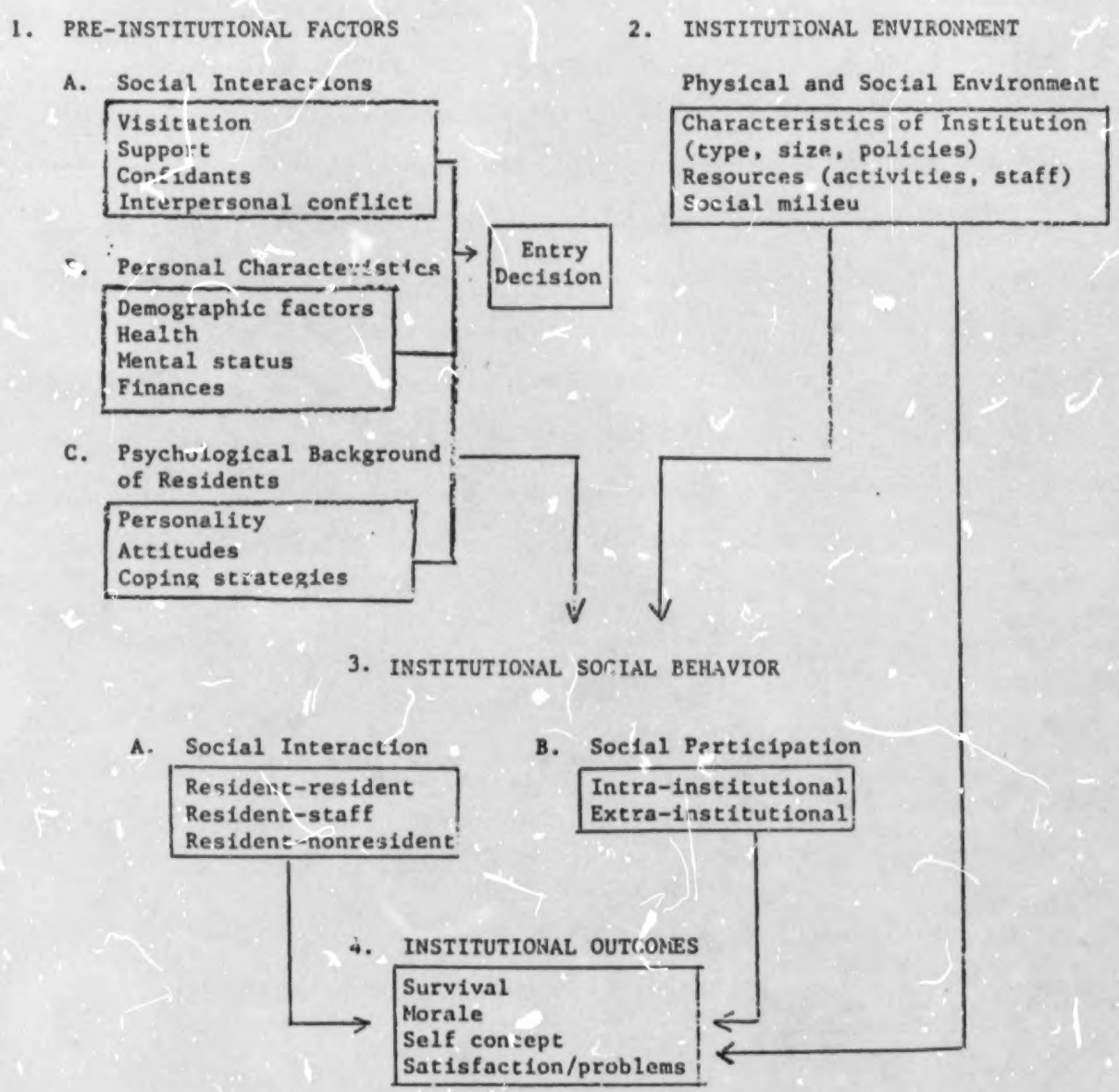
5. Another concern is with sequelae of social interactions as they affect the psychosocial functioning of the resident. Institutional life may bring about changes in social interactions which in turn influence psychosocial well-being, resulting in increased or decreased morale, self esteem or life satisfaction.

These concerns actually relate to the location of social factors in the institutional paradigm. They may be among the antecedents, correlates, outcomes or predictors of institutional behavior. Figure 1 illustrates this paradigm.

In this chapter, the authors aim to review and integrate previous research related to social aspects of institutional life. In addition, data will be presented from a recently completed longitudinal study of the initial year of institutional living (Kahana and Kahana, 1978). Researchers had followed prospective residents from the pre-institutional stage through their initial adjustments and through the first year of life in the institution. Older persons entering diverse institutional environments were also compared with a group of residents entering a senior citizens' housing site. The study encompassed self reports of the elderly regarding life in the institution, perspectives of staff and interviewers' observations of social interactions among respondents.

Figure 1

MODEL OF SOCIAL FACTORS IN INSTITUTIONAL LIFE



The literature reviewed and the research presented address only selected aspects of the proposed paradigm. In particular, little attention has been paid to the variation in the nature of long term care institutions. While one study may refer to skilled nursing homes another may be based on personal care homes or homes for the aged. The preponderance of research relevant to social interactions of the institutionalized aged has been based on mildly impaired ambulatory residents receiving basic nursing care.

Attention should also be called to ambiguities involved in definition of variables and limitations of prevailing measurement approaches. The assessment of institutional social interactions typically focuses on counting numbers of visitations, joint activities, friends or confidants, verbal exchanges among residents, or similar indications. Generally, little research has addressed the symbolic meaning of social ties or the emotional gratification specifically derived from interpersonal interactions. Furthermore, gerontological studies seldom employ formal network analysis in considering the social world of the institutionalized aged.

In spite of the above noted limitations, elements of previous research may be considered in the broader framework outlined in the conceptual model. In this manner, both gaps in knowledge and potentially useful areas for future research on the social world of the institutionalized elderly may be identified.

REVIEW OF PREVIOUS WORK

1. Pre-Institutional Factors

A. Social Factors Contributing to Institutionalization

Diverse background factors have been cited as contributing to decisions of the elderly to enter institutions (Tobin and Lieberman, 1976). Some researchers have focused primarily on personal frailty, ill health, and

inability for continued independent living (Hickey, 1980). Others have emphasized lack of informal and/or formal social supports as most important in bringing about institutionalization (Gelfand and Olsen, 1980; Lowenthal and Haven, 1968; Tobin and Lieberman, 1976). The very process of institutionalization may be seen as symbolizing society's withdrawal from the older person (Riley and Foner, 1968).

It is increasingly recognized, however, that an interaction between personal vulnerability and loss or inadequacy of social supports is ultimately most likely to bring about institutional placement (Lawton, 1980). In a national survey of the health of older persons, Shanas (1962) found that greater numbers of functionally impaired older persons continue living independently in the community than are placed in institutions. Those remaining in the community in spite of severe incapacity are able to do so because of the availability of formal and/or informal social supports.

A little explored factor in institutional entry decisions is concern by the elderly about being a burden to others (Kalish, 1969). Physicians and other health care providers may also play an important role in institutionalization of older persons, ranging from the actual decision making to legitimizing family discussions about institutionalization of the older person (Hickey, 1980).

In summary, the data on social factors in entry to institutions tend to support Lawton's (1980) view that the deteriorating balance between ability for self care and social supports is usually responsible for institutional placements.

B. Personal Background of Residents

There is a paucity of research directed at understanding personal antecedents of institutional social life. Research by Kosberg (1973) suggests

that resident characteristics frequently covary with institutional resources. Accordingly, he found that minority elderly and those with limited financial resources are often institutionalized in facilities lacking in resources.

Those elderly who had been socially isolated prior to entering institutions appear to have the greatest difficulty in learning the social norms of the institutions (Granick and Nahemow, 1961). This group was also found most likely to encounter problems and conflicts in interacting with other residents. Using a dependency model, Goldfarb (1969) argues that institutions' failure to meet residents' dependency needs results in negative post-institutional outcomes.

While research on family relations of the institutionalized aged reveals active visitation patterns, it appears far more difficult for residents living in institutions to continue maintaining contact with previous friends. Kahana and Harel (1972) found that 76% of those interviewed want to continue associations with old friends. Nevertheless, barriers exist in terms of accessibility of the institution to community elderly who frequently have transportation and health problems and few friends who can continue regular visitation. The very limited research in this area nevertheless underscores the heuristic value of considering personal background and social orientation as they impact on the social world of the institutionalized aged.

2. Institutional Environment

Goffman's (1961) classical treatise, Asylums, exemplifies the "moral career" of the institutionalized person by depicting the life of the inmate of a mental hospital. He argues that interactions with others in an institutional setting strip the inmate of his previous identity. The physical and social environment of the institutional setting plays an important role in defining social opportunities and lives of the institutionalized elderly.

There is a sizeable body of research addressing the role of physical environmental characteristics in shaping the social life of the resident. There is relatively little research, however, dealing with the impact of the social environment of institutions on resident social interactions.

Institutional social interactions among residents appear to be facilitated by spatial proximity and by organized group activities (Riley and Foner, 1968). In a study by Friedman (1966) it was found that friendship choices were most common among residents living on the same floor. There is conflicting evidence regarding size of institutions and their impact on social interactions. In a study by Curry and Ratliff (1973), residents of larger homes appeared more isolated than those in small homes, both in terms of interactions with other residents and staff. In contrast, Lemke and Moos (1980) found greater social participation and resident involvement in decision making among residents of larger homes.

Some research evidence supports the hypothesis that social withdrawal of institutionalized aged may be a response to lack of physical privacy (Ward, 1984). Conversely, it has been argued that private rooms in nursing homes may increase social interaction among residents (Lawton, 1970; Goldfarb, 1977). Underlying these expectations is the notion that territoriality is an important determinant of social behaviors.

The value of territorial markers in enhancing social interactions has been tested in an experimental study (Nelson and Paluck, 1980). In another effort at environmental manipulation to increase resident social interactions, furniture was rearranged in the dayroom of one facility to decrease territorial norms which reinforced isolation (Sommer, 1970). More attractive and better organized physical settings were related to increased verbal interactions, but residents also demonstrated some degree of confusion and

resistance to change. These findings are congruent with earlier research (Lipman, 1968) suggesting that enforced proximity and fixed seating arrangements discourage social interactions in institutional settings.

Institutional norms, as part of the social environment have been considered as potential predictors of the degree of intimacy or distance between residents. These can regulate the degree of contact and the type of interactions occurring among residents and also between staff and residents (Lieberman and Tobin, 1983). Provision of socially oriented group activities has been shown to increase the general level of engagement by the elderly (McCormack and Whitehead. 1981). Greater institutional totality and regimentation of residents has been found to diminish patterns of interactions in institutions (Bennett, 1963). The importance of formal and informal aspects of the social environment in affecting social behavior was confirmed in a study by Kiyak and Kahana (1979). Research in thirteen nursing homes and homes for the aged revealed that informal norms appear to have greater effect on residents' behavior than formal institutional policies.

3. Institutional Social Behavior

A. Social Interactions among Residents

Loss of access to old friends may combine with problems in making new ones to diminish social interactions of the institutionalized aged (Ward, 1983). Yet in considering legitimate goals of an institution, the elimination of isolation and opportunities for developing social contacts have been cited as major objectives (Hickey, 1980). Those elderly who had been socially isolated prior to entering institutions had the greatest difficulty in learning the social norms of the institutions (Granick and Nahemow, 1961). They were also most likely to encounter problems and conflicts in interacting with other residents.

Goffman (1961) outlines the dynamics of social interactions among residents of total institutions. He argues that initial perceptions of one another tend to be negative. After the initial period of institutional adaptation a "fraternization" process begins. This process allows formation of social bonds which are not colored by negative attributes of other residents. Based on qualitative in-depth observations of a nursing home, Gubrium (1975) provides valuable insights into resident and staff behavior. He depicts residents as spending a considerable portion of their time and effort either maintaining or avoiding social ties. Cliques, reflecting efforts at establishing friendships and supports, were commonly found on individual floors. At the same time, efforts were often directed at avoidance of certain residents. These resident-resident interactions and avoidances were seldom encouraged by staff.

A study by Baltes et al. (1983) investigated almost 5000 interactions of 40 elderly residents and their social partners in a nursing home providing intermediate care. Fifty percent of the interactions occurred with staff, 35% involved other residents and 15% occurred with non-residents. Interactional profiles of residents were similar across length of institutionalization, sex and health variables. When residents exhibitted dependent behaviors, social partners (both staff and other residents) typically responded by showing support. However, this research did not distinguish between interactions occurring among residents versus those involving both staff and residents.

B. Staff-Resident Interactions

The specific nature of staff-resident interaction has been considered primarily in terms of dependency inducing or caretaking behaviors by staff (Behn and Stewart, 1982; Kiyak and Kahana, 1984). Gottesman and Bourestrom (1974) studied 1144 residents in 40 nursing homes in Michigan by behavioral

observations. During a two-day period, 73% had no social contact with anyone on the staff. Residents were observed in contact with persons other than staff only 17% of the time. Gubrium (1975) considered dynamics of staff-resident interactions and found that top staff used four sources of knowledge to learn about residents. These included charts, anecdotes, incidental information and "serious interviews." This latter source is the only one based on interpersonal contact with residents. Watson and Maxwell (1977) found that severity of physical and medical impairment of residents is closely related to withholding of care and assistance by institutional staff. Differences in racial composition of residents and staff also affect social interactions between residents and staff.

Staff behavior and interaction with the elderly were studied observationally by Kiyak and Kahana (1984) in four institutions. The most common social interactions involved behaviors in which staff treated residents as equals. Dependency inducing behavior was minimal and staff were observed exhibiting positive affect towards residents. A different impression is conveyed when residents' perspective is considered. Spasoff et al. (1978), in a longitudinal study of institutionalized elderly, indicates that residents believe they develop increasing dependency on the staff during the course of the first year of institutional living.

Self-reports of residents' or patients' interactions with staff in the majority of studies indicate resident satisfaction with treatment by staff (Kahana and Kahana, 1984). However, it is possible that these reports are tainted by social desirability factors. As has been argued (Blau, 1973), the elderly appear passive and "mellow" in order to avoid alienating those on whom they depend.

Studies which have focused on routine interactions among residents and staff provide little evidence for establishment of actual social ties or emotional bonds between the two groups. One reason for lack of deeper involvement may be the differential perceptions of residents by staff and by the residents themselves. In a study by Kahana and Coe (1969), residents were found to express views of self related to previous social roles and past experiences. In contrast, staff assumed a strictly management oriented view of residents, considering them primarily in terms of degree of care they required.

It is important to note that diverse types of staff are not usually differentiated. Yet it is well known that residents interact primarily with lower level staff, particularly aides (Gottesman and Bourestrom, 1974). Top staff, on the other hand, play an important role in determining norms and social climate of the institution (Gubrium, 1975).

C. Resident-Nonresident Interactions

Although institutionalization has often been depicted as reflecting abandonment of the aged by members of the family (Brody, 1977), recent research does not support this view (York and Calyson, 1977). In a study by Seelbach and Hansen (1980), institutionalized elderly persons, resembling noninstitutionalized aged, expressed overwhelming satisfaction with family relations. Results obtained by Smith and Bengtson (1979) showed improved family solidarity subsequent to institutionalization. According to these authors, improvements in family ties are likely to occur because institutionalization eases the demands and strains placed by an elderly parent on his or her children.

4. Institutional Outcomes and the Role of Social Factors

Recent studies have investigated factors which can mediate adverse effects of institutionalization. Social support and interaction has been considered to be useful in facilitating more positive outcomes. Availability of social supports seems to play an important role in mitigating the effects of deteriorating physical and mental functioning (Wan and Weissert, 1981). In one study, institutionalization per se was not found to have significant effects on residents' self esteem, but self esteem was found to covary with social interactions (Newman, 1964).

Pastalan (1972), based on an extensive review of research on home-to-institution relocation, concludes that there was better adjustment among elderly who sought interactions following their move, than among those who withdrew from activities. A recent study by Wells and MacDonald (1981) focused on residents' interaction with family, staff and other residents. Data indicated that close primary relationships were associated with successful adjustment to relocation. A different view is suggested by the work of Walsh and Kiracofe (1980). Their research indicates that when social networks of the institutionalized aged change, there is a shift away from relatives as salient members of the social network. The authors suggest that this shift in salient relationships away from the family may represent an important factor for successful adjustment in retirement homes.

EMPIRICAL STUDY OF COPING WITH INSTITUTIONAL LIFE

Having reviewed previous research related to social factors in institutional life, we will now turn to a more detailed presentation of an empirical study completed by the investigators which addresses several elements of the model outlined above. This research may be viewed as a case study which highlights both problems and potentials in focusing on the social

world of the institutionalized aged. It should be noted that the central focus of the research was on the relationship of diverse coping strategies to post-institutional outcomes. Nevertheless, extensive information was obtained concerning diverse aspects of the social world of the elderly entering institutions.

Sample and Procedures

Data presented in this research were obtained from a four-wave longitudinal study of adaptation of the elderly to institutionalization (Kahana and Kahana, 1979). Two hundred fifty-three older adults entering long-term care facilities were interviewed just prior to relocation or shortly after. Thirty-five persons who moved into an apartment complex for the aged comprised a comparison group. In addition to pre-move assessments, interviews took place 2 weeks, 3 months, and 8 months after the move.

Fourteen institutions in two Midwestern cities comprised the facilities. These were both proprietary and non-profit charitable or religious institutions. They were centered in three metropolitan areas and were primarily in urban environments, with some suburban and rural representation. Half of these settings combined nursing home licensure with home for the aged or board and care home licensure. Eleven were sponsored by religious institutions (5 Jewish, 4 Protestant, 2 Catholic institutions) and four were non-sectarian, but religious sponsorship did not limit residence to adherents of that faith. There was an average bed capacity of 203 and none of the facilities had fewer than 100 beds. Respondents comprised newly admitted clients to self care or intermediate care divisions of institutions. Only ambulatory residents who were able to participate in an interview were included in the sample.

Respondents were fairly typical of those described in previous research on institutionalized aged. The mean age of the sample was 79.2 years and three-fourths were female. Sixty one percent were widowed, 13% were married, 9% divorced or separated and 10% had never married. They were not seriously limited in either health or mental functioning. Health scores averaged 6.4 on a scale of 4 to 8 (low scores represented good health). Mean mental status scores were 7.5 on a scale ranging from 0-10, where 0 reflected total disorientation to time, place and person. It is noteworthy that these persons were more impaired physically and mentally than the community comparison group.

MEASURES

The study employed multimethod assessment strategies including resident interviews and staff and interviewer ratings of respondents. The variables which comprised the focus of the study correspond to some of the components of the model of social factors in institutional life. As presented earlier in Figure 1, pre-institutional social factors, institutional social behavior and post-institutional well-being are interrelated aspects of the social world of the institutionalized. Five sets of indices developed to measure social factors included: 1) socially oriented reasons for entering the institution, 2) socially relevant coping strategies, 3) social participation, 4) social interaction, and 5) socially oriented problems encountered in the facilities. Measures of psychosocial well-being indicated respondents' health (Rosow Health Scale, 1967), morale (Lawton Morale Scale, 1975), self esteem (Coopersmith's Self-Esteem Inventory, 1967), and mental status (Kahn, Pollack and Goldfarb's Mental Status Questionnaire, 1961).

Socially oriented entry factors were one group of entry reasons among others (social, personal-emotional, residential or health) indicated by

respondents as reasons for institutional move. These comprised the first measure of social behavior. The second measure, socially relevant coping strategies, utilized a subscale of the Elderly Care Research Center Coping Scale (Kahana, Fairchild and Kahana, 1982). The strategies included: talking with others about the problem; getting together with people who have the same problem; complaining about the problem to people with authority; or depending on trusted people to deal with the problem. Social participation was indicated by the number of group activities which residents reported they engaged in, ranging from sedentary activities to those requiring physical endurance (dancing and recreational classes). Social interaction was determined by self reports enumerating persons respondents talked to, felt close to, visited with and received assistance from. Socially oriented problems were determined by responses to open ended questions regarding personal, social and environmental difficulties. These were also coded in terms of staff-related, resident-related, self-related, outsider-related and environment-related problems.

RESULTS

Results of this study presented a more benign portrait of institutional life than that observed in a number of previous works (Lieberman, 1969; Gubrium, 1975). Residents not only survived the move and early adjustment period but generally found life in a congregate facility to be no worse than they expected and in many instances, better than they expected. They exhibited moderate levels of morale, self esteem and health and these remained stable or increased slightly during the first year of institutional living.

Major differences prevailed between the institutionalized and non-institutionalized groups in the study. Residents of long term care facilities were significantly older and more likely to have moved for health or interpersonal reasons. They also differed substantially in health status and psychosocial well-being from the non-institutional elderly. Morale, physical health and mental status scores all were significantly higher among those moving to the senior citizens' apartment than among new institutional residents.

Some interesting patterns of changes were noted three months after the move for both the institutionalized and senior housing groups. Each group gained in self esteem and health and showed a slight improvement in mental status. However, significant differences in morale favoring community elderly were no longer observable. Morale of nursing home residents increased slightly, while community living elderly showed a slight decline. Due to these differential patterns of change the groups differed significantly after the three month period only with respect to mental functioning. These data underscore the general observation of the present study that institutional life does not adversely affect psychosocial well-being of the elderly. In considering these results, it should be noted that data were gathered in facilities which all offered high quality services. In addition, sampling procedures generally favored elderly who were relatively unimpaired physically and mentally. While the focus of this report is a general mode of adaptation to institutional living, differences both in environmental features and personal characteristics of entrants to different institutions should be noted. Residents entering different institutions represented a broad spectrum of physical and mental status scores. Facilities also differed significantly in social opportunities available and social participation.

Pre-Institutional Factors: Social and Personal

In contrast to the portrayal of isolated elderly who enter institutions (Lowenthal and Haven, 1968), most persons in this study did not live alone and had family or friends nearby. There were other people they visited with, talked to, were helped by, or lived with. Only about one of ten respondents (11%) reported there was no one to whom they felt particularly close. Less than half (48%) lived alone, one third (31%) with children or other relatives and 13% resided with spouses. About two-thirds of the respondents indicated they felt closest to their children, spouses, or other family members rather than friends. Neighbors were cited as confidants by only 23% of respondents.

Those awaiting entry to institutions reported fairly active visitation patterns. More than half (58%) reported visitations at least once weekly and 32% indicated several visitors or visits made in the last month. Family, friends and neighbors comprised the major visiting networks. Families provided the main source of social support during the year prior to institutionalization to the 61% of respondents who received help. Nevertheless, it is noteworthy that 39% of those entering institutions neither sought nor received assistance.

However, further consideration of the data also revealed incidents of relative deprivation and isolation emerged. One-fourth (24%) of the respondents did not have confidants and the majority had only one other person they talked to regularly (mean score of 1.03 for the institutionalized group). Similar results were found for numbers of persons respondents felt close to. The range was from none to four and averaged 1.5. Only 7% were close to three or more people.

When numbers of confidants and close interpersonal relationships among institutionalized and community living aged were compared, the relative isolation of elderly entering institutions was confirmed. Significant differences emerged in number of others respondents were close to and talked problems over with. The institutionalized aged also had significantly fewer visitors. These findings confirm the conclusions of previous studies regarding the role of social isolation and absence of confidants as an important factor in institutional placements of the elderly.

The primary motivating factors for institutional entry were frequently social in nature. Almost one-half (48%) of the respondents cited these, in contrast to 10% and 20% of the sample, respectively, who noted personal-emotional factors and health needs and 22% who mentioned residential-environmental considerations. Among the socially oriented reasons for moving were rejection by children, death of a spouse, not wanting to be a burden, concern over being alone, or desire for greater interpersonal integration. This type of response was reflected by such statements as: "I wanted to be out of the way of my son and daughter-in-law, but I don't want to be alone", "I'm hoping to meet people my age and get interested in living again", "I'm alone so I should be someplace where they will check on me."

In striking contrast were the reasons mentioned for entry to the elderly apartment facility. Less than one-third (29%) of tenants cited socially relevant reasons for moving and few indicated health or personal-emotional considerations (each mentioned by less than 5%). Neighborhood and housing considerations ranked first among the non-institutionalized group.

Decisions to enter institutions often involved significant others and were frequently shared (39% made the decision alone, 48% shared it and other persons were the sole deciders in 10% of the cases). Family members,

specifically children, were most frequently reported as those helping to make the entry decisions. In contrast, professionals were rarely involved, noted by only 9% of those entering institutions. These results are in contrast to observations in the medical sociology literature (Hickey, 1980) about the importance of physicians in entry decisions. Some of these differences may be based on sampling strategy in the present study where only respondents entering institutions from independent living arrangements were included in the sample.

Psychological Background of Residents

Most of those anticipating the move to an institution appeared willing or even eager to move (80%) and expected their stay to be permanent (82%). Residents reported that they moved with fairly clear expectations and seventy-nine percent had visited the home themselves. Although for most of the respondents the visit was not a comprehensive one, the majority (57.9%) did have a tour of the residence and talked to the staff (65.7%).

Social orientation of respondents prior to institutionalization was reflected in our study in socially focused coping strategies. When diverse coping strategies were compared, four socially focused items were among the most frequently endorsed by residents. Only one of the four social coping strategies ranked below the top third of the 22 item array. The strategy of "talking with others about the problem" was selected by almost three-fourths (72%) of respondents. These results indicate that interpersonal contact plays a very important role in instrumental problem resolutions of the elderly. They indirectly support Goffman's (1961) notions that interpersonal integration represents a crucial technique for coping with life in institutions.

Institutional Social Contacts and Behavior

Three months after entry to the institution social interaction of residents was assessed. Some contact with others both inside and outside the institution were found to be common. Few residents reported no one to whom they generally talked (12%) or were close to (7%). Yet, social contacts were also generally limited. The number of person residents talked to or were close to resembled pre-move figures. Forty-eight percent reported regular conversations with only one other person. Mean numbers of persons talked to was 1.2 and people close to was 1.5. Married persons were close to more people and talked to greater numbers than did the non-married. Although sex differences were not significant, it is noteworthy that women appeared less socially isolated than were men.

Respondents were frequently visited in the institution. Indeed, 64% reported visits at least once a week from their most regular visitor. Major visitors were family members. Relatives were the only visitors received by 27% of the sample but 13% were never visited by families, reporting all visitors as non-kin. Children were most frequently mentioned as visitors, 40% citing children. They were also noted as individuals residents were most likely to talk things over with.

Families were involved with respondents in other ways, particularly in providing assistance. Despite the availability of staff in the institutional setting, 17% of those receiving aid reported a family member as their first choice of aid.

Interaction between residents and staff was considered, based on both staff and resident reports. Frequent contact with residents was cited by staff two weeks after institutionalization. Staff reported knowing about one-third of the respondents well (38%) and over one-half (58%) slightly. In evaluating

resident adjustment, staff reported that two of ten persons (19%) experienced great difficulty in the first days after admission and that there were adjustment problems in 57% of the cases.

Staff reports regarding care provided confirmed the generally intact physical and mental status of the sample. Whereas 36% required almost no care and just 6% very much, over one-half (56%) were considered to need little or some care.

Resident reports three months after entry generally indicated no problematic staff interaction. Only about one of ten (13%) mentioned difficulties with staff and these tended to involve nurses and their attitudes toward residents. Half of those with staff complaints reported that nurses were curt. These data confirm earlier research suggesting that institutional aged generally portray little dissatisfaction with staff.

Social Participation

The majority of respondents reported that they participated in some organized social activity at the institution. The range of these activities was quite wide, encompassing both sedentary and active recreational pursuits. Religious services, movies, choral groups, exercise classes and trips outside the institution were among activities mentioned, although not all institutions offered all. Most frequently engaged in were participatory activities such as games and bingo. Hobbies and religious participation respectively were cited as ranking second and third.

Three distinct patterns of social participation were observable. A small number of residents (17%) were involved in 4 or more activities portraying a very active level of participation. The majority (48%) reported engaging in 1-3 different social activities. It is interesting to note that one-third of the sample did not participate in any organized activities of the institution. The

range of activities engaged in reflects only one aspect of participation. It is possible, of course, that for some residents regular participation in even one activity affords opportunities for intense social involvement. Some marital status differences in activity levels were observed. The married were most likely to portray very high levels of participation (four or more activities), with 24% of the married group versus 16% of the non-married exhibiting this pattern.

When differences in social participation according to marital status are coupled with findings of greater visitation and social interaction among the married, these data suggest that having a spouse may provide the institutionalized older persons with a stable base of social support and interaction. Married individuals appear to be more socially engaged both in terms of visitations and conversation patterns than any of the non-married categories of widowed, divorced, separated or never married.

Interpersonal Conflict

The present study also provides some basic descriptive data regarding the prevalence and nature of the difficulties or conflict experienced by residents in a variety of institutional environments. Among the difficulties reported, interpersonal problems were not as common as those relating to personal or environmental concerns. Interpersonal problems were reported by 34% of respondents, while 51% and 43% respectively mentioned personal or environmental difficulties. Twenty-one percent experienced problems with family and friends and 13% with staff.

The most frequent type of conflict with other residents involved roommates (54% of those with interpersonal problems were found to have this type of difficulty). Problems with family tended to involve lack of visitation rather than interactional difficulties. Thus, it is lack of contact rather than

conflict which characterizes problems in family-resident relation.

When we compared these problems with type of entry decision (socially relevant or non-socially relevant reasons) little congruence was noted. Persons who moved for interpersonal reasons were no more likely to have problems with other residents than those who entered for other reasons (29% of each group reported resident problems). However, they were somewhat more likely to experience problems with family insofar as frequency of contact. Twenty-one percent of those who moved for socially related reasons reported problems with family or friends, compared to 13% of those moving for other reasons. This may indicate that interpersonal conflict within the family which may have contributed to the entry decision can persist even as the person remains institutionalized.

Change in Social Behavior Subsequent to Institutionalization

In view of the vast changes institutional life brings, changes in social behavior were expected. Indeed there was some small gain in social contact after institutionalization. However, findings from this study indicate stability in the social interactions of the elderly entering institutions. No significant change occurred in either numbers of people respondents were close to (pre-institutional mean of 1.48, institutional mean of 1.52) or total number of people talked to (pre-institutional mean of 1.03 and institutional mean of 1.21).

Family visitation also changed little although family aid patterns changed after institutionalization. Whereas over 50% of the pre-institutional assistance had been given by families there was a sharp drop to 17% after relocation, which may reflect the availability of assistance from staff or other residents.

While institutionalization can provide new opportunities for social interaction, the vast majority of persons felt close to the same person 3 months after entry as prior to relocation (73%). However, married respondents were much more likely to mention no change in confidants (80%) than did the non-married. Only about six of ten of the latter retained the same person as a confidant. Married respondents generally talked to their spouse about matters of concern, while widowed respondents talked to children and never married to relatives. Overall our data confirm the general portrait of post-institutional stability described by Lieberman and Tobin (1983).

Although the modal pattern observed was stability in social interactions, a notable one-third of the residents expanded or contracted their social contacts by increasing or decreasing their networks by two or more persons. The expanders and contractors were almost equal in number (34 expanders and 35 contractors), each accounting for 18%. In considering what differentiated the three groups, some interesting contrasts emerged. Age proved to be an important variable, with expanders being older. Thus, expanders averaged 82 years in contrast to the mean age of 75 for contractors and 79 for the stable group. Sex and marital status did not prove important. The greater likelihood of older respondents to expand social interactions may be due to limited interpersonal opportunities of the very old living independently in the community. They are likely to suffer from lack of access to friends and even unavailability of social activities and partners. For this group, institutionalization may afford renewed social opportunities, and they can expand their social world after entry.

Based on the expectation that increasing social interactions may enhance psychosocial well-being, the three groups reflecting different patterns of change in social interactions were also compared for changes in morale in that

greater social contact could be beneficial. Findings indicate that the majority of each group remained stable. Social expanders were no more likely to demonstrate enhanced morale than were contractors or stables. These data point to only limited utilization of social opportunities afforded by communal, age heterogenous environments of institutions by new residents. It is interesting to note, however, that the very oldest residents demonstrate greatest likelihood of availing themselves of new social opportunities.

Changes in Coping

In considering coping style of residents after institutionalization, the basic pattern found was one of stability. Three of the four socially oriented coping strategies considered changed little. Likelihood of usage three months after institutionalization was almost identical to what had been the case prior to entry. However, one strategy, complaining to people in charge, showed a linear increase in usage, rising from a pre-entry level of 42% to 59%. This change points to situational factors which may enhance the salience of some social coping strategies. Specifically, congregate living may require the elderly to engage those in charge in attemptng to deal with problem situations. Data in terms of general stability of coping confirms the notion that coping strategies have traitlike as well as situation specific components (Kahana, Fairchild and Kahana, 1982).

Several noteworthy findings also emerged pointing to the important role of diverse coping strategies in predicting survival and psychosocial outcomes. In the larger study, coping strategies were considered in terms of instrumental, affective and escapist modes of coping.

Data analyses indicated the prevalence of instrumental coping strategies among elderly respondents. These and avoidance/escape strategies were found to be related to positive outcomes such as survival, high morale and self concept.

In contrast, affective coping strategies (i.e., emotional expressions) were related to negative post-institutional outcomes. Thus, it appears that the institutionalized older person who is willing and able to take instrumental action in dealing with problem situations fared well, as did the person who tended to deny stress.

Respondents' social participation during institutional life was related to psychosocial factors such as health, mental status, self esteem and morale. Pre-entry health and mental status were both found to have little correlation with self-reported social activity at T3. Neither predicted greater social activity. However, three months after entry, social participation and some of the psychosocial measures were significantly correlated. Respondents' morale and Mental Status Quotient were associated with social participation. Persons with greater involvement in social activity demonstrated higher morale ($r=.19$, $p<.01$) and mental functioning ($r=.14$, $p<.05$).

Psychosocial outcomes for residents who were more socially isolated prior to entry versus the more socially engaged did not appear to vary greatly. There were no significant differences in self esteem, morale of health three months after relocation among persons who had no visitors or were close to no one and those who had no visitors or confidants.

Based on the correlational nature of these data, directions for causality can only be inferred, and the actual role of social activity in enhancing morale or mental alertness avails further study.

Discussion and Conclusions

In contrast to previous literature about constricting effects of institutional living, this research point to opportunities for social contact. Older persons living in institutions received frequent visitors from outside had generally pleasing interactions with other residents and staff and

participated in activities available at the facility. There was also a category of older people for whom there is an initial expansion of social contacts and redefinition or extension of previous social relationships with family and friends. For this group the crisis of institutionalization may have mobilized latent social resources for these older persons much as it did for those Lowenthal and Berkman studied in San Francisco (1967). However it should be noted that a comparable minority also reported shrinking of their social world.

Findings of the present study did not provide a portrait of the relatively intact, recently institutionalized elderly as isolated, withdrawn or stripped of opportunities for social interaction. Nevertheless, the social opportunities potentially posed by age homogenous communities did not appear to materialize in institutional settings. There is little evidence based on the data for widespread emergence of close and meaningful social ties among the institutionalized elderly. For most elderly, the first year of institutional life is characterized by both relative psychological and social stability.

Numerous factors interact in a complex fashion to shape the interpersonal world of the older resident. These include initiatives from others, i.e., family, friends, staff or even other residents. Initiative from the older person based on personal orientation and psychological characteristics may represent another. The institutional physical and social environment may serve to facilitate or thwart such initiatives. In the present study, it was not possible to specify the degree to which external and internal variables determine expansion or contraction of social relationships. Nevertheless, in the framework of this longitudinal study it is possible to consider correlates of changes in social interaction patterns.

The study reviewed also calls attention to differential perspectives on the social world of the elderly institutionalized person when considered from vantage points of the residents, staff and outside observers. A multi-method study design allows for consideration of these diverse elements. Nevertheless, an in depth analysis of the personal or symbolic meaning of social ties was not clearly articulated by these data.

Perceptions of the qualitative value of interactions assume importance on par with actual behavior. Especially when options are limited, perceiving social support as accessible rather than remote may help to reduce some aspects of cognitive dissonance. It is also quite possible that the behavior of friends and relatives is actually quite different after the move even where visitation and formal ties continue. Information about the existence of social conflict in the institution primarily as involving other residents also calls attention to the complex dimensionality of social relations. Previous research has focused on social interactions among residents generally only as reflecting "fraternization" or friendship ties. The role of social conflict both as a precipitant of institutionalization and an aspect of institutional living deserves additional attention in future research. Conversely, greater emphasis on the nature and meaning of helping by the elderly of one another also represents an area of study with potential heuristic value.

In considering previous studies dealing with social life of the institutionalized aged, a dual pattern seems to emerge. Holistic studies of life in institutions which were conducted in the 1960's and 1970's point to a rather negative picture of diminished social ties and abandonment of the institutionalized aged by family and friends. In contrast, more recent empirical research which generally examines only selected aspects of the social interactions of institutionalized aged depicts stability or improvement in

social contact subsequent to institutionalization.

The increased social interactions which are possible in institutions, as well as the greater attention afforded to the elderly by health care professionals, may be the ingredients which contribute to the well-being of the elderly in good quality institutions. Different conclusions arrived at by different studies may also be a function of secular changes since reports are often based on different cohorts. Furthermore, qualitative studies may provide holistic and impressionistic views of institutional life while quantitative reports present reliable data only on parts of the gestalt. Quantitative studies consistently portray the institutionalized aged as active participants in their social world, seeking to maintain interpersonal engagement interaction. Yet, they reveal relatively little about the intensity or meaning of social ties for their group.

In considering social problems, as well as social opportunities inherent in institutional living, it should be noted that communal living may be difficult for older persons even outside of institutions. Streib (1979), in his review of alternative communal living arrangements for older persons, points out that both the social structure and existence of private possessions may make adjustment to congregate life problematic.

Research on institutions has been criticized as being of variable quality. Methodological problems abound. Samples may be restricted to a few unrepresentative facilities which are interested in sponsoring or permitting research. As our research pointed out, considerable differences exist in institutions. Not only are the physical and social environment diverse, but residents differ in characteristics. Some facilities serve the more impaired elderly while others are orientated toward ambulatory, alert persons. Therefore, inter-institutional differences should be addressed in reports

about the effects of institutionalization. An additional problem is posed by the fact that control groups are seldom available and there is little comparability of measurement across studies (Riley and Foner, 1968). Furthermore, inherent in much of the research on institutions are the conceptual problems of separating effects of selection, relocation and institutionalization (Lieberman, 1969).

In addition to methodological problems in studies of the social world of the institutionalized aged, there is a general absence of clear conceptual guidelines or theoretical orientations to guide research in this area. Both qualitative and quantitative studies tend to be descriptive and reflect an empirical orientation. Potentially relevant conceptual frameworks, such as those articulated by sociologists (Goffman, 1961) and psychologists (Seligman, 1969), are seldom specifically tested in research on institutions. Articulation of the conceptual framework withing which research is embedded, represents a necessary first step toward advancing our understanding, rather than just our data base, about the social world of the institutionalized aged. In the introduction of this paper, we aimed to take a small step in the direction of explicating the domains relevant to the study of social factors among the institutionalized aged. It should be noted that our own data drawn from a larger study exploring theoretical issues of coping among the institutionalized aged only addressed a few aspects of these domains. We are currently in the process of designing research which will meaningfully tie together qualitative and quantitative approaches in understanding the social world of the institutionalized aged.

In spite of the limitations outlined, data based on diverse studies confirm the view that close social relations are relatively uncommon among older persons in institutions. This absence of close interpersonal ties may

not be a function of institutionalization per se. Instead, it is likely to reflect diminished social opportunities with significant others as persons age, which may have precipitated institutionalization in the first place.

It is also important to note that characteristics of institutionalized aged have been changing in recent years and may be projected to change further in the future. As community alternatives are increasingly available to even the frail elderly, residents of institutions are likely to become older and more vulnerable, often requiring skilled nursing care. For elderly whose mobility is restricted and who suffer from severe physical and mental impairment, social opportunities of institutional living may also be increasingly limited. Interactions with visitors and staff may take a special importance for this group of frail elders. Yet, even as the nature of the social world of those living in institutions may be altered, the importance of interdependence and social relations is certain to prevail.

REFERENCES

Baltes, M. M., Honn, S., Baron, E. M., Orzech, M.J. and Lago, D. On the social ecology of dependence and independence in elderly nursing home residents: a replication and extension. Journal of Gerontology, 1983, 38, 5, 556-564.

Behn, J. D. and Stewart, B. J. A behavioral study of the service provision encounter. Paper presented at the 35th Annual Meeting of the Gerontological Society of America, Boston, Massachusetts, November, 1982.

Bennett, R. The meaning of institutional life. The Gerontologist, 1963, 3, 117-125.

Blau, Z. S. Old age in a changing society. New York: Franklin Watts, 1973.

Borup, J. H., Gallego, D. and Heffernan, P. Geriatric relocation. Ogden, Utah: Weber State College Press, 1978.

Brody, E. M. Long-term care of older people. New York: Human Sciences Press, 1977.

Carp, F. M. Person-environment congruence in engagement. The Gerontologist, 1968, 8, 184-188.

Coe, R. M. Self-conception and institutionalization. In A. M. Rose and W. A. Person (Eds.), Older people and their social world. Philadelphia: F. A. Davis, 1965.

Coopersmith, S. The Antecedents of Self-Esteem. San Francisco: W.H. Freeman, 1967.

Curry, T. and Ratliff, B. The effects of nursing home size on resident isolation and life satisfaction. The Gerontologist, 1973, 13, 295-298.

Friedman, Edward P. Spatial proximity and social interaction in a home for the aged. Journal of Gerontology, 1966, 21, 566-570.

Fry, C. Structural conditions affecting community formation among the aged. In J. Keith (Ed.), The ethnography of old age. Special issue of Anthropological Quarterly, 1979, 52, 1, 7-18.

Gelfand, D. E. Visiting patterns and social adjustment in an old age home. The Gerontologist, 1968, 8, 272-275.

Gelfand, D. and Olsen, J. The aging network: programs and services. New York: Springer, 1980.

Goffman, J. E. Asylums: essays on the social situation of mental patients and other inmates. Garden City, New York: Doubleday, 1961.

Goldfarb, A. I. Institutional care of the aged. In E. W. Busse and E. Pfeiffer (Eds.), Behavior and adaptation in late life. Boston: Little, Brown, 1977.

Goldfarb, A. I. Predicting mortality in the institutionalized aged. Archives of General Psychiatry, 1969, 21, 172-176.

Gottesman, L. E. and Bourestrom, N. C. Why nursing homes do what they do. The Gerontologist, 1974, 14, 501-506.

Granick, R. and Nahemow, L. D. Preadmission isolation as a factor in adjustment to an old age home. In P. H. Zubin and J. Zubin (Eds.), Psychopathology of aging. New York: Grune and Stratton, pp. 285-302, 1961.

Gresham, M. L. The infantilization of the elderly: a developing concept. Nursing Forum, 1976, 15, 195-210.

Gubrium, J. E. Living and dying at Murray Manor. New York: St. Martin's Press, 1975.

Hendel-Sebestyen, G. Role diversity: toward the development of community in a total institutional setting. In J. Keith (Ed.), The Ethnography of old age. Special issue of Anthropological Quarterly, 1979, 52, 1, 19-28.

Hickey, T. Health and aging. Monterey, California: Brooks/Cole, 1980.

Jasnau, K. F. Individualized versus mass transfer of non-psychotic geriatric patients from mental hospitals to nursing homes with special reference to the death rate. Journal of the American Geriatric Society, 1967, 15, 280-284.

Kahana, E. Environmental adaptation of the aged. In T. Byerts (Ed.), Housing and environment for the elderly. Washington, D.C.: Gerontological Society of America, 1975.

Kahana, E., Fairchild, T. and Kahana, B. Adaptation. In D. J. Mangen and W. A. Peterson (Eds.), Clinical and social psychology; Vol. I. Research instruments in social gerontology. Minneapolis: University of Minnesota Press, 1982.

Kahana, E. and Harel, Z. Social and behavioral principles in residential care settings for the aged: the residents' perspective. Part II. Position paper prepared for presentation at the Annual Meeting of the Orthopsychiatric Association, Detroit, April, 1972.

Kahana, E. and Kahana, B. Institutionalization of the aged woman: bane or blessing? In M. Haug, M. Sheafor and A. Ford (Eds.), The physical and mental health of aged women. New York: Springer, 1984.

Kahana, E. and Kahana, B. Strategies of coping in institutional environments. Summary progress report, NIMH grant number MH24959-04, 1978.

Kahana, E. and Kahana, B. Strategies of coping in institutional environments. Final progress report, NIMH grant number MH24959-04, 1979.

Kahn, R. L., Pollack, M. and Goldfarb, A. I. Factors related to individual differences in mental status of institutionalized aged. In P. Hock and J. Zubin (eds.), Psychopathology of aging. New York: Grune and Stratton, 1961.

Kalish, R. A. The dependencies of old people Occasional paper #6. Journal of Gerontology, 1969.

Keith, J. Old people as old people: social and cultural influences on aging and old age. Little, Brown Series on Gerontology. Boston: Little, Brown, 1982.

Kiyak, A. and Kahana, E. Personal and job related predictors of employee turnover in facilities for the elderly. Paper presented at the 36th Annual Scientific Meeting of the Gerontological Society of America, San Francisco, November, 1983.

Kiyak, H. A. and Kahana, E. Attitudes and behavior of staff in facilities for the aged. Paper presented at the 35th Annual Scientific Meeting Meeting of the Gerontological Society of America, Boston, November, 1982.

Kiyak, H. A. and Kahana, E. The role of informal norms in determining institutional totality in homes for the aged. Long term care and health services administration quarterly, 1979.

Kosberg, J. I. The nursing home: a social work paradox. Social Work, 1973, 18, 104-110.

Lawton, M. P. Aging and the environment. San Francisco: Jossey-Bass, 1980.

Lawton, M. P. The Philadelphia Geriatric Center morale scale: A revision. Journal of Gerontology, 1975, 30, 85-89.

Lawton, M. P. Ecology and aging. In L. A. Pastalan and D. H. Carson (Eds.), Spatial behavior of older people. Ann Arbor, Michigan: University of Michigan-Wayne State University Institute of Gerontology, 1970.

Lemke, S. and Moos, R. Assessing the institutional policies of sheltered care settings. Journal of Gerontology, 1980, 35, 96-107.

Lieberman, M. A. Institutionalization of the aged: effects on behavior. Journal of Gerontology, 1969, 24, 330-339.

Lieberman, M. A. and Tobin, S.S. The experience of old age. stress, coping, and survival. New York: Basic Books, 1983.

Lipman, A. A socioarchitectural view in three old people's homes. Gerontologia Clinica, 1968, 10, 88-101.

Lowenthal, M. F. Lives in distress. New York: Basic Books, 1964.

Lowenthal, M. F. and Berkman, P. L. Aging and mental disorder in San Francisco: a social psychiatric study. San Francisco: Jossey-Bass, 1967.

Lowenthal, M. F. and Haven, C. Interaction and adaptation: intimacy as a critical variable. American Sociological Review, 1968, 33, 20-30.

McCormack, D. and Whitehead, A. The effect of providing recreational activities on the engagement level of long-stay geriatric patients. Age and Aging, 1981, 10, 287-291.

Nelson, M. N. and Paluck, R. J. Territorial markings, self-concept, and mental status of the institutionalized elderly. The Gerontologist, 1980, 20, 1, 96-107.

Newman, N. C. Institutionalization, interaction, and self-conception in aging. Unpublished master's thesis, University of Minnesota, 1964.

Pastalan, L. Studies on relocating the elderly. Paper presented at the Gerontological Society's Annual Meeting, San Juan, Puerto Rico, 1972.

Riley, M. W. and Foner, A. Aging and society: volume one; an inventory of research findings. New York: Russell Sage Foundation, 1968.

Rosow, I. Social Integration of the Aged. New York: Free Press, 1967.

Seelback, W. and Hansen, C. Satisfaction with family relations among the elderly. Family Relations, 1980, 29, 91-99.

Seligman, M. E. Control group and conditioning: a comment on operationism. Psychological Review, 1969, 76, 5, 484-491.

Shanas, E. The health of older people. Cambridge, Massachusetts: Harvard University Press, 1962.

Smith, K. and Bengtson, V. F. Positive consequences of institutionalization: solidarity between elderly parents and their children. The Gerontologist, 1979, 19, 438-447.

Sommer, R. Small group ecology in institutions for the elderly. In L. A. Pastalan and D. H. Carson (Eds.), Spatial behavior of older people. Ann Arbor, Michigan: University of Michigan-Wayne State University Institute of Gerontology, 1970.

Spasoff, R. A., Kraus, A. S., Beattie, E. J., Holden, D.E., Lawson, J. S., Rodenburg, M. and Woodcock, G. M. A longitudinal study of elderly residents of long-stay institutions: 1. early response to institutional care. The Gerontologist, 1978, 18, 3, 281-292.

Streib, G. F. An alternative family form for older persons: need and social context. The Family Coordinator, 1979, 27, 413-420.

Tobin, S. S. and Lieberman, M. A. Last home for the aged: critical implications of institutionalization. San Francisco: Jossey-Bass, 1976.

Townsend, P. The last refuge: a survey of residential institutions and homes for the aged in England and Wales. London: Routlage and Kegan Paul, 1962.

Walsh, J. and Kiracofe, N. Change in significant other Relationships and Life satisfaction in the aged. International Journal of Aging and Human Development, 1980, 10, 273-281.

Wan, T. T. T. and Weissert, W. G. Social networks, patient status, and institutionalization. Research on Aging, 1981, 3, 2, 240-256.

Ward, R. A. The aging experience: an introduction to social gerontology, 2nd ed. New York: Harper and Row, 1984.

Watson, W. H. and Maxwell, R. T. Human aging and dying: a study in socio-cultural gerontology. New York: St. Martin's Press, 1977.

Wells, L. and McDonald, G. Interpersonal networks and post-relocation adjustment of the institutionalized elderly. The Gerontologist, 1981, 21, 2, 177-183.

York, J. L. and Calyson, R. J. Family involvement in nursing homes. The Gerontologist, 1977, 17, 500-505.